MEETING of the DOD
TASK FORCE ON THE PREVENTION OF SUICIDE
BY MEMBERS OF THE ARMED FORCES

10 November 2009

Marriott
5151 Pooks Hill Road
Bethesda, Maryland 20814 USA

1. ATTENDEES

PRINCIPAL MEMBERS & REPRESENTATIVES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
	Ms.	Embrey	Ellen	Performing Duties of the ASD for HA
X	MG	Volpe	Philip	Joint Task Force National Capital Region Medical, Task Force Co-Chair
X	Ms.	Carroll	Bonnie	Tragedy Assistance Program for Survivors, Task Force Co-Chair
	Dr.	Wilensky	Gail	President, Defense Health Board
	CDR	Feeks	Edmond	Executive Secretary, Defense Health Board
x	Col	Bader	Christine	Senior Advisor to the Assistant Secretary of Defense Health Affairs
X	Dr.	Berman	Alan	American Association of Suicidology
X	COL	Bradley	John	Walter Reed Army Medical Center
Via Phone	Dr.	Certain	Robert	St. Peter and St. Paul Episcopal Church
X	CMSgt	Gabrelcik	Jeffery	Air Force Review Boards
	SgtMaj	Green	Ronald	Headquarters Marine Corps Arlington, Va. 22214
	Dr.	Holloway	Marjan	Uniformed Services University of the Health Sciences

	Dr.	Jobes	David	The Catholic University of America

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
	Dr.	Kemp	Janet	Veteran's Administration
X	Dr.	Litts	David	Suicide Prevention Resource Center/Education Development Center, Inc.
X	Dr.	McKeon	Richard	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
X	Col	McPherson	JoAnne	DOD Task Force on Prevention of Suicide by Members of the Armed Forces Office of the Secretary of Defense/Health Affairs
x	MGySgt	Proietto	Peter	Senior Enlisted Advisor CMC (SD) Navy Annex
x	CDR	Werbel	Aaron	Headquarters, Marine Corps (MRS) Quantico, VA 22134

GUESTS & OTHER ATTENDEES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	LTC	Ueoka	Alan	JTF CAPMED
X	Dr.	Cox	Daniel	Postdoctoral Fellow Department of Medical and Clinical Psychology Uniformed Services University of the Health Sciences
X	Mr.	Girman	David	US Army MEDCOM
X	Ms.	Girman	Jean	US Army
X	Dr.	Hoge	Charles	WRAIR
X	Cpt.	Stehr	Emily	USAMEDDAC, Fort Drum, NY
X	Mr.	Warren	Wright	Gallup Washington, D.C
X	Mr.	Shabaz	Bruce	Army, Office of the VCSA
X	Ms.	Miller	Heather	DcoE
X	Mr.	Funk	Denise	TriWest
X	Ms.	Helen	McCarty	Gallup

X	AC1	Yager	Taylor	82 TRW/TA Sheppard AFB
X	Mr.	Way	J.	SPAN USA
X	Dr.	House	UNK	University of Maryland
X	Ms.	Rocco	Kim	TAPS
X	BG	McGuire	Colleen	Army Suicide Task Force
X	Mr.	Ure	UNK	CNN

2. ADMINISTRATIVE SESSION (closed)

3. OPENING REMARKS AND INTRODUCTIONS

MG Volpe welcomed attendees to the meeting of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces and then explained the role of the Task Force under the Defense Health Board. MG Volpe asked CDR Ed Feeks to officially call the meeting to order.

CDR Feeks officially welcomed the Task Force members and the public to the meeting. CDR Feeks explained that he was the alternate designated federal officer for the Defense Health Board, a federal advisory committee and a continuing independent scientific advisory body to the Secretary of Defense, via the Assistant Secretary of Defense for Health Affairs, and called the meeting to order.

MG Volpe asked the attendees to stand for a moment of silence in honor of military service members.

MG Volpe asked the Task Force members and the speakers to introduce themselves. Members of the Task Force and the speakers introduced themselves. MG Volpe introduced Col McPherson as the new Executive Secretary of the task force.

Col Joanne McPherson, Executive Secretary, welcomed everyone to the meeting and provided administrative announcements. She stated that the next meeting of the Task Force will be held on Tuesday, December 15, 2009 at the same Pooks Hill Marriott in North Bethesda, and will focus on the investigations portion of the Task Force's responsibilities. She suggested that attendees visit the DHB web site to obtain more information.

Col McPherson welcomed the first speaker, COL (Ret) Charles Hoge, to the panel for his presentation. (Biography attached).

4. EPIDEMIOLOGICAL AND PUBLIC HEALTH PERSPECTIVES IN MILITARY SUICIDE RESEARCH, WRAIR

COL (Ret) Charles Hoge presented, "**Epidemiological and Public Health Perspectives in Military Suicide Research, WRAIR**". (Briefing attached)

SUMMARY OF PRESENTATION:

Suicide Rates

- In 1990-2000 the crude rate of suicides, military-wide, varied from 10.7 to 14.1, depending on the branch of Service. When adjusted demographically -- age, gender, and race – the rates leveled out in the Army, Marines, and Air Force, in the 12-14% range, but the Navy rate was substantially lower than the other services at around 10.7%. When adjusting for "over-boards" and counting them as suicides rather than undetermined, however, the Navy's rate suicide rate was similar to the other Services.

- Of all Army suicides from Jan 2003-Jul 2009 45% had received one or more behavioral health diagnoses, 15% had inpatient treatment, and 7% had a history of a prior attempt.

- The most consistent factors identified in suicide reports are deployment length, multiple deployments, relationship problems, financial and legal problems, increased use of alcohol and drugs, increased family violence, access to weapons, and behavioral problems.

Increased Suicide Rate Evidence:

1. Increased population prevalence of mental disorders due to combat operations (e.g. PTSD, depression, anxiety, substances)

2. Multiple deployments involving ground combat operations with relatively short dwell times

3. Increased use of SSRIs and other psychotropic medications (FDA Black Box Warning) SSRIs are commonly prescribed by primary care and BH professionals; commonly used in theater.

4. Stigma /barriers have increased. Preventive interventions are not efficacious.

5. The resilience of the population is changing due to changes in recruitment standards or accession of a less fit force.

- Dr. Hoge discussed the effects of dwell time. MHAT IV recommended that the dwell time should be 18 to 36 months. General Casey referred to the MHAT Report indicating that based on an Army report, the dwell time – the optimal dwell time -- needed to be two years in order to get people back down to more or less baseline rates of PTSD and depression.

- Dr. Hoge discussed OEF Behavioral Health Status regarding to PTSD (Acute Stress), Depression and Anxiety. Hoge also mentioned the MHAT VI study and stated that the results are similar to previous MHAT studies.

- There is no direct data on multiple deployments and suicide as yet; however, it is currently being actively looked at.

Dr. Hoge discussed Prevention / Intervention Strategies such as:

- Education / Stigma Reduction / Resiliency Training
- Post-Deployment Screening (PDHA/PDHRA

- Surveillance
- Treatment

Dr. Hoge discussed PDHA/PDHRA processes

- Clinicians do not know how to correctly use information that is collected by the service members when they come back from deployment.
- Risks: Labeling & Stigma of service members who do not have a mental disorder.
- There are false positives in the diagnostics test. Many people who do not have PTSD will be screened as having PTSD and the reverse.

Recommendations:

1. Mental health treatment needs to be more routine in primary care, so when the soldiers and Marines and Airmen come in for sick call, they can see a mental health professional just as easily as they see a primary care professional.
2. The PDHA/PDHRA process needs to be evaluated.
3. Continue analyses, and particularly with adjustment for demographics such as age, race, and gender.

SUMMARY OF QUESTIONS AND DISCUSSION:

- Dr. Hoge stated that he did not know whether the increase in suicide rates in the military reflects a national increase, however, he felt it was very unlikely. Dr. Hoge explained that the Air Force and Navy are doing something different from the Army and Marine Corps regarding programs.

- Whether dwell time and reset is more important than deployment length and multiple deployments was discussed. Hoge replied that the MHAT VI report will have that information. The MHAT Report should be released by November 14, 2009.

- The quality of surveillance relative to the depth of the data or the standardization of data collection relative to completed suicides or relative to potential mental disorders was discussed. Dr. Hoge stated that it is fair to say that there are undiagnosed mental problems or mental disorders in individuals who are suicidal.

- Dr. Hoge stated that he did not know the level of training of primary care physicians in assessing suicide risk in the military.

- Whether there was evidence in the civilian sector of changes in prescribing practices among physicians since the black box warning was questioned. Hoge replied that he does not know if there is evidence. He doubted that the information was out because of the barriers to service members receiving twelve sessions of psychotherapy for PTSD (night training exercises, deployment activities, etc.) Evidence suggests that for the treatment of PTSD, psychotherapy is more effective than medications. Service members get SSRI treatment because it's effective for PTSD. It may not be quite as effective as psychotherapy, but it's effective.

- The visibility into suicides for Guard and Reserve not in a duty status or active duty post-120 days of ETS was discussed. Hoge stated that once an individual leaves the military or demobilizes their

suicide was rarely visible. Hoge suggests that Millennium Cohort Team is linking in with the death registry data to help capture suicide visibility.

5. DEFENSE CENTERS OF EXCELLENCE

Col McPherson introduced BG Sutton. (Biography attached)

BG Sutton presented, **"**Defense Centers of Excellence" (briefing attached)

SUMMARY OF PRESENTATION:

- BG Sutton gave a brief summary of the Defense Centers of Excellence and their accomplishments, explaining DCoE's five guiding principles and seven strategic goals.

DCoE's Six Component Centers

1. Center for Deployment Psychology
    - Primary Contact: David Riggs
    - The center is not just mental health providers, but extends to primary care and is now reaching out to TRICARE and civilian providers.
2. Center for the Study of Traumatic Stress
    - Primary Contact: Bob Ursano
    - Responds to all major disasters
3. Defense and Veterans Brain Injury Center
    - The DVBIC was recognized nationally as the top clinical integrated care system for brain injuries.
4. Deployment Health Clinical Center
    - RESPECT-Mil (the Re-Engineering Systems of Primary Care Treatment in the Military)
5. National Center for Telehealth & Technology
    - Primary Contact: Dr. Greg Gahm
    - Harness and leverage these growing capabilities
    - Responsible for the DoD Suicide Event Report (DoDSER)
6. National Intrepid Center of Excellence
    - Global network of networks
    - Opening in the spring of 2010

Programs:

- Theater of War
- RESPECT-Mil
- The Real Warriors Campaign
- Afterdeployment.org (AD)
- DCoE's 24/7 Outreach Center
- DoD/VA Suicide Prevention Conference

Suicide Prevention Studies

- RAND Center and the National Defense Research Institute (NDRI)
- The Caring Letter Pilot Project
- The National Institute of Mental Health (NIMH) an inter-disciplinary team conducting the largest study of suicide and mental health among military personnel ever undertaken. $50 million in funding from the Army.
- Suicide Prevention and Counseling Research (SPCR)

Suicide Prevention Oversight:

- The DoD Suicide Event Report (DoDSER)
  Managed by the National Center for TeleHealth and Technology (T2), one of DCoE's six component centers
  Provides over 250 data points per suicide with details, summaries and analysis of a wide range of potential factors contributing to suicide attempts and completions

- Suicide Prevention and Risk Reduction Committee (SPARRC)
  SPARRC is a forum for developing /expanding partnerships
  Committee's goal is to improve policies, programs and systems across DoD
  Group provides support for medical, line, and community leaders
  SPARRC includes representatives from all Services, VA, SAMHSA, CDC, Medical Examiners, Chaplains, Telehealth/Technology and National Guard/Reserves

SUMMARY OF QUESTIONS AND DISCUSSION:

- BG Sutton stated that DCoE is working with organizations such as Samueli Institute and the NIH Biomedical Center in order to develop a research focused side. She explained that hiring individuals is a hard task both in hiring and bringing them on board. BG Sutton estimated that the VA has hired 4,000 additional behavioral health professionals and the TRICARE network has also hired thousands more.

- Discussed the responsibility to analyze surveillance data and make specific prevention recommendations. BG Sutton stated that DCoE is working with the RAND Corporation to help analyze the DoDSER data.

- Dr. Thomas Joiner's "Why People Die by Suicide" has three factors that have validity and relevance for challenges within the military and family population. The three "D's" the most important factor is displacement.
  - Displacement
  - Distortion
  - Desensitization

- BG Sutton mentioned that challenges are mainly in middle management. An E-7 platoon sergeant told her that that the military "suck it up" culture is not serving the troops well. BG Sutton feels the need to intervene as early as can be. And that the military is working together as a nation to transform our culture to one of resilience and strength.

- Dr. McKeon asked when the DoDSER Report will be released. BG Sutton responded that she will contact MG Volpe when the report is available for the Task Force.

- The "Got Fuel" "Got Sleep" impact was discussed. BG Sutton stated that it is a toolkit with questions patterned after the "Got Milk?" advertising campaign. It is currently being developed in hopes to be in an integrative game to attract troops. BG Sutton mentioned 7 of the 8 "Gots" as Got Sleep?, Got Fuel?, Got Friends?, Got Love?, Got Face?, Got Hope?, and Got Growth? (Note: The eighth "Got" was not mentioned and is not covered in her presentation.)

- Recommendations from BG Sutton:
    - BG Sutton stated that there should be more white space (ie, too many tasks, too many demands on our brains) in our individual lives.
    - She mentioned that the military culture takes front line leaders away from knowing their troops. Without knowing their troops, a front line leader will not be able to help because they will never know the kinds of problems their troops are having.

6. ARMY HEALTH PROMOTION AND RISK REDUCTION CAMPAIGN

Col McPherson introduced BG Colleen McGuire.(Biography Attached)

BG McGuire presented the "Army Health Promotion and Risk Reduction Campaign". (Briefing Attached)

SUMMARY OF PRESENTATION:

- BG McGuire discussed the pre-transformation Army where reducing risk increased the likelihood of success. Today, the Services applaud and promote risk taking and it's even codified in doctrine.

- BG McGuire provided statistics for Active Duty suicides and Non Active Duty suicides between 01 January - 02 November for calendar years 2001-2009. The numbers of suicides for both populations has increased every year for those particular months. No inferences were provided related to those statistics.

- Indications of increasing risk such as infidelity, excessive alcohol use / abuse, high risk driving, multiple drug use offenses & mitigation such as relationship counseling, financial counseling and assistance, administrative separation, and increased drug use testing were presented.

- BG McGuire discussed Army STARRS Study (via NIMH).
    - Study to Assess Risk and Resilience in Service Members
    - The goal of study is to develop data-driven methods for mitigating or preventing suicide behaviors and improving the overall mental health and behavioral functioning of Army Personnel.
- BG McGuire discussed redundant / disparate programs and organizations.
    - There is no standard suicide mitigation program in the Army.

SUMMARY OF QUESTIONS AND DISCUSSION:

- Dr. Berman asked about the indications of increasing risk factors that the Army has identified or has instituted active outreach interventions or specific programs to respond individually and/or in

combination with others. BG McGuire replied that there are about 400 different programs such as alcohol, substance abuse and ASAP. For the infidelities factor there is a Strong Bonds Program, and other family-oriented programs.

- BG McGuire mentioned that although there are risk factors, there isn't evidence that these risk factors specifically cause suicide. It is the accumulation and bioaccumulation based on an individual's resilience capability.

- BG McGuire indicated that the prevalence of suicide risk factors such as substance abuse may be at an increased level.

- BG McGuire discussed that with the urgency of the suicide problem, the first phase is to do a quick identification of all existing programs, conduct a very rudimentary assessment of a quantitative nature, and then grouping or binning like-programs together.

7. USACHPPM BEHAVIORAL AND SOCIAL HEALTH OUTCOMES PROGRAM (BSHOP) UPDATE

Col McPherson introduced LTC Michael Bell.

LTC Michael Bell presented "**USACHPPM Behavioral and Social Health Outcomes Program (BSHOP) Update**".

SUMMARY OF PRESENTATION:

- LTC Michael Bell addressed the mission and capabilities of BSHOP.

- LTC Michael Bell spoke of epidemiology of suicide in the US Army as in the US Army suicide rates from 1990-2008,

    - ARMY suicide rate trends, by component
    - US ARMY suicides: method of death
    - Army Suicides: CY 2001 through 31 JULY 2009
    - ARMY suicide rate trends, by age group
    - Army suicide rate trends, by rank
    - US Army suicides 2003-2009 by mental health diagnoses.

- Discussed statistics related to several slides including:
    - Underlying factors of the burden of injuries and diseases for US Army active duty population (injury, mental, signs/symptoms, etc);
    - US Army mental health trends in 2001-2008;
    - US Army modifiable risk factors of suicide 2005-2008,
    - The four types of stigma (career, leadership, peer-to-peer, and personal).

- Discussed Population health perspectives to include:
    - Multi-factorial risk model, risk mitigation strategies,
    - Population based strategies for suicide mitigation, and
    - Public health process applied to multi-dimensional suicide prevention strategy

SUMMARY OF QUESTIONS AND DISCUSSION:

- Dr. Litts asked whether gender distribution is known to be different with some of the groups with lower rates. LTC Bell answered that the gender distribution of any group is almost exclusively male and only 5 percent of Army suicides are among females.

- LTC Bell mentioned that CHPPMS next report, which is coming out in a few weeks, will be adjusted for age, race, and sex.

- LTC Bell mentioned that the research based on the focus groups was done at Fort Carson last winter.

- A report was released in July of this year with an appendix on the focus group methodology and details of the result are available on the Internet. LTC Bell could provide a copy. The report includes a follow-up investigation at Fort Carson with another brigade.

7. PANEL DISCUSSION

- Dr. Berman asked how the outcomes of the training programs are measured and evaluated. Dr. Hoge stated that the only randomized control trial of training was done on post- deployment Battlemind training. Outcomes such as depression were measured and evaluated through scores in the depression measure, scores in the PTSD measure, reduction of stigma, changes in behavior, and alcohol-related incidents.

- Dr. McKeon asked about way inpatient care and outpatient care was taking place within the military. LTC Bell replied that data is captured as long as an individual has care that the Army bought and paid for. However, if there is a diagnosis prior to coming into the Army, the only way it can be captured is through a suicide event report. Therefore, capturing data would be very incomplete in terms of outside treatment.

- Col Bradley asked about the timeframe for treatment visits relative to the suicide. LTC Bell replied that he has an analysis that observes treatment within the 30- or 90-day period prior to the suicide. LTC Bell mentioned that if he could come back he will present that data to the Task Force.

- LTC Bell explained that there are no effective training programs in place that are proven to increase individual resiliency, but the Army has a long history of increasing unit resiliency or unit cohesion.

- LTC Bell explained that he recognizes that the data that he presented is unsatisfying on a number of levels and mentioned that his next report, which is due out this month, should address several concerns.

- Staffing, resources, and finances were discusses regarding to getting data about suicide prevention.

- Dr. Hoge explained that WRAIR's Psychological Resiliency Research Program does not focus on suicide. It's primarily been focused on PTSD, TBI, sleep deprivation, MHAT studies, and other

research. The US Medical Research and Material Command (USMRMC) has recently started a suicide task area.

8. SERVICE MEMBER PANEL DISCUSSION

Service Member Panel Discussion
Col McPherson introduced service members CPT Emily Stehr (US Army), Cpl Kaitlyn Scarboro-Vinklarek (US Marine Corps) and A1C Taylor Yager (US Air Force). All three Service members are suicide attempt survivors.

CPT Stehr Recommendations:

- Take care of emotional injuries. It enhances our ability to achieve the objective and helps our service members and their families live better lives.
- Bring more awareness of suicide into the Army.
- Testimonials are a better way of bringing awareness than PowerPoint presentations.

Cpl. Kaitlyn Scarboro-Vinklarek Recommendations

- Add personality back into the military.
- Educate all leaders of the military about suicide prevention and install a "care for others" approach.
- Create more interactive awareness for suicide, such as the Marine Corps suicide prevention training for NCOs.

AlC Yager Recommendations:

- Incorporate the human element back into the military culture**.**
- Reduce stigma as well as being labeled crazy, incompatible with military standards and unfit for service.
- Remove the shame of suicide.

MG Volpe and Col McPherson thanked all the speakers and the service members for their presentations and testimony.

MG Volpe turned the meeting over to CDR Feeks. CDR Feeks Adjourned the meeting.

MEETING ADJOURNED